INSTRUCTIONS FOR COMPLETING THE CONFIDENTIAL REQUEST FOR LOCAL HEALTH DEPARTMENT ASSISTANCE FOR PARTNER COUNSELING & REFERRAL SERVICES

Michigan Law, Public Act 489 and 86, allow for physicians and local health officers to refer HIV positive patients and/or sex and needle-sharing contacts/partners to local public health for assistance with partner notification. By completing and submitting the attached form to local public health, attempts will be made to confidentially contact the individual and provide HIV/AIDS education, risk reduction information, and in case of partner(s), HIV test referral or testing. This form can be useful when referring infected individuals for assistance with partner notification who request to be reported anonymously.

INSTRUCTION:

Line 1. Please mark the appropriate box designating your request for assistance with partner notification for the **HIV/AIDS-Infected Individual,** or an **At-Risk Partner** (*Check only one*)

Line 2. **Name**: Enter the full name (last, first) of the individual you are referring for assistance with partner notification.

Line 3. **Street Address/Phone**: Enter the residential address and street name of the individual being referred. Also, indicate a home or alternate telephone number.

Line 4. **City/State/Zip Code/County**: Indicate the name of the city, state, zip code individual you are referring.

Line 5. **Place of Employment/Phone**: Enter the place of employment and telephone number for the individual you are referring.

Line 6/7. **Sex/Pregnant/Marital Status**: Indicate the sex, if client (female) is pregnant, and marital status of the individual you are referring.

Line 8. **Date of Birth/Age**: Enter the date of birth and age of individual you are referring.

Line 9. **Race**: Enter the race/ethnicity of the individual you are referring.

Line 10. **LaboratoryTest/Individual Informed of Result**: Indicate the test results of the HIV/AIDS-Infected individual you are referring, and if the person was informed of test result.

Line 11. **Referral Provider Name**: Indicate the name of the provider who is making the referral.

Line 12/13. **Facility Address/ Phone/City/ State/Zip Code/County**: Indicate the facility address, telephone number, name of the city, state, zip code, and county.

Line 14. **Person making referral other than provider**: Enter the name, and phone of the person, if different than the physician, who is making the referral (nurse, counselor, case manager.)

Line 15. **Date of Referral**: Enter the month, day and year of the referral.

Line 16. **Provide Any Additional Information**: Document any other information (environmental, medical, physical, psychological…) which may be important to the follow-up care of this individual. If available, also include the unique identifier number, obtained from the HIV Event System (HES) for the individual being referred.

Line 17. **Mail To**: Enter the mailing address of the health department, and the name, and the phone number of the designee who will receive this referral. In most counties, this individual is usually the AIDS Coordinator. Only indicate the fax number if the referral will be sent to the health department via a secured fax number.

Note: *All notification efforts conducted by local public health are confidential. At no time will the name of the infected individual be disclosed to an identified partner.*